MARYLAND DUAL ELIGIBLES CARE DELIVERY INITIATIVE

STAKEHOLDER WORKGROUP - OCTOBER 18, 2016

AGENDA

- How Duals Model Connects to Additional Maryland Design Efforts
  - Primary Care Model Development
  - All-Payer Model Progression
- Theory of Change – Drivers of Duals ACO Model
- Refinement of Features of D-ACO Model
  - Geography
  - Beneficiary Designation of D-ACO
  - Care Redesign
  - Roles and Responsibilities of D-ACO and PCHH
  - Quality Measurement
  - Payment for Care Coordination
  - Risk Sharing
- Primary Care Model Development Update
- Next Steps - Engagement Process

DUALS INITIATIVE IS INTEGRATED WITH MARYLAND'S WIDER HEALTH CARE TRANSFORMATION EFFORTS

D-ACO Model aligns with principles of the **primary care model** and refinements to the **all-payer model**. It tests a different payment mechanism and introduces entities that may take broad accountability for these high-risk beneficiaries.

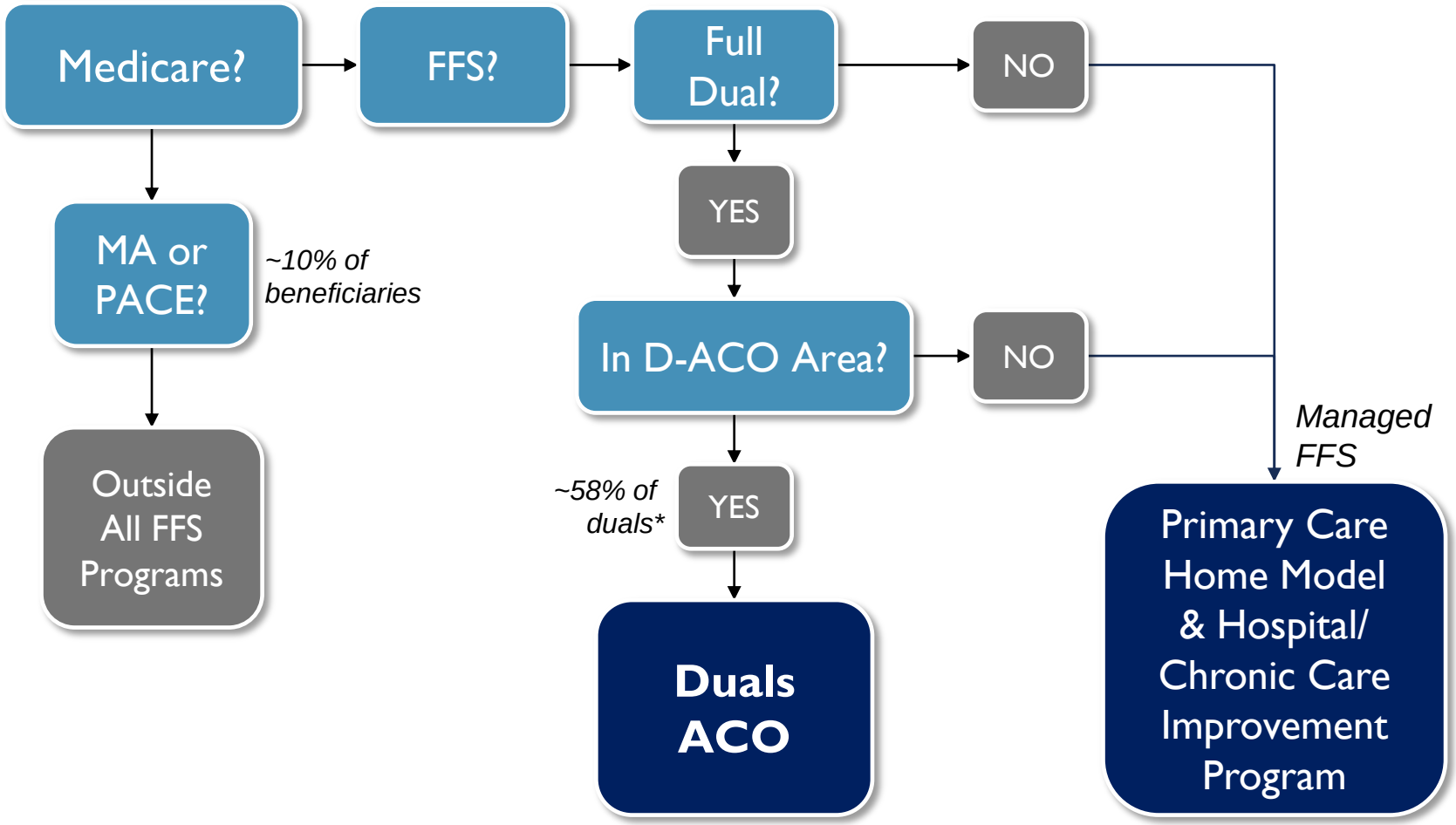
Duals Accountable Care Organizations

- Primary Care Model
- Regional Partnerships
- Complex and Chronic Care Program and Hospital Care Improvement Program
- Geographic Model

Features in Common

- Person-Centered Health Home
- Data Exchange and Analytics
- Care Coordination
- Population Health
- MACRA: Advanced APMs

MOST FULL DUALS WILL GO INTO A D-ACO



* 90% of full duals are in FFS Medicare; 64% reside in D-ACO area

D-ACO'S PERSON-CENTERED HEALTH HOME LEVERAGES PLANNED PRIMARY CARE TRANSFORMATION

- PCHH blends elements of Primary Care Medical Home, Chronic Health Home
  - Serves as person's first source of care and care coordination quarterback
- PCHH fully aligns with the Primary Care Model (PCM)
  - Specialty (including BH) providers and NF-based providers allowed as PCHHs
  - Will follow standards set by PCM; may be enhanced to serve distinct needs of duals
  - Structural and performance expectations will align with MACRA standards for Advanced Alternative Payment Model

THEORY OF CHANGE: D-ACO'S DRIVE ACCOUNTABILITY FOR QUALITY AND EFFICIENCY

Current FFS System		Duals ACO Model
Beneficiaries lack a go-to provider	-------	Patient-designated provider who is care coordination quarterback
Discontinuity in care, especially across physical, behavioral, LTSS and social domains	-------	Seamless coordination across health care settings and spanning to social supports
Provider incentives reward volume and intensity of services	-------	D-ACO materially accountable for total cost of care plus quality
Repetition of assessments, testing, procedures	-------	Care coordination tools enable access to data -- assessments, tests, medical encounters Promote standardized processes and assessments
Lack of provider capacity to coordinate care	-------	Incentivize providers and offer resources to coordinate care

THEORY OF CHANGE CHARACTERIZED IN DRIVER DIAGRAM

Goal

Achieve and Sustain High-Value Coordinated Care for Dual Eligibles

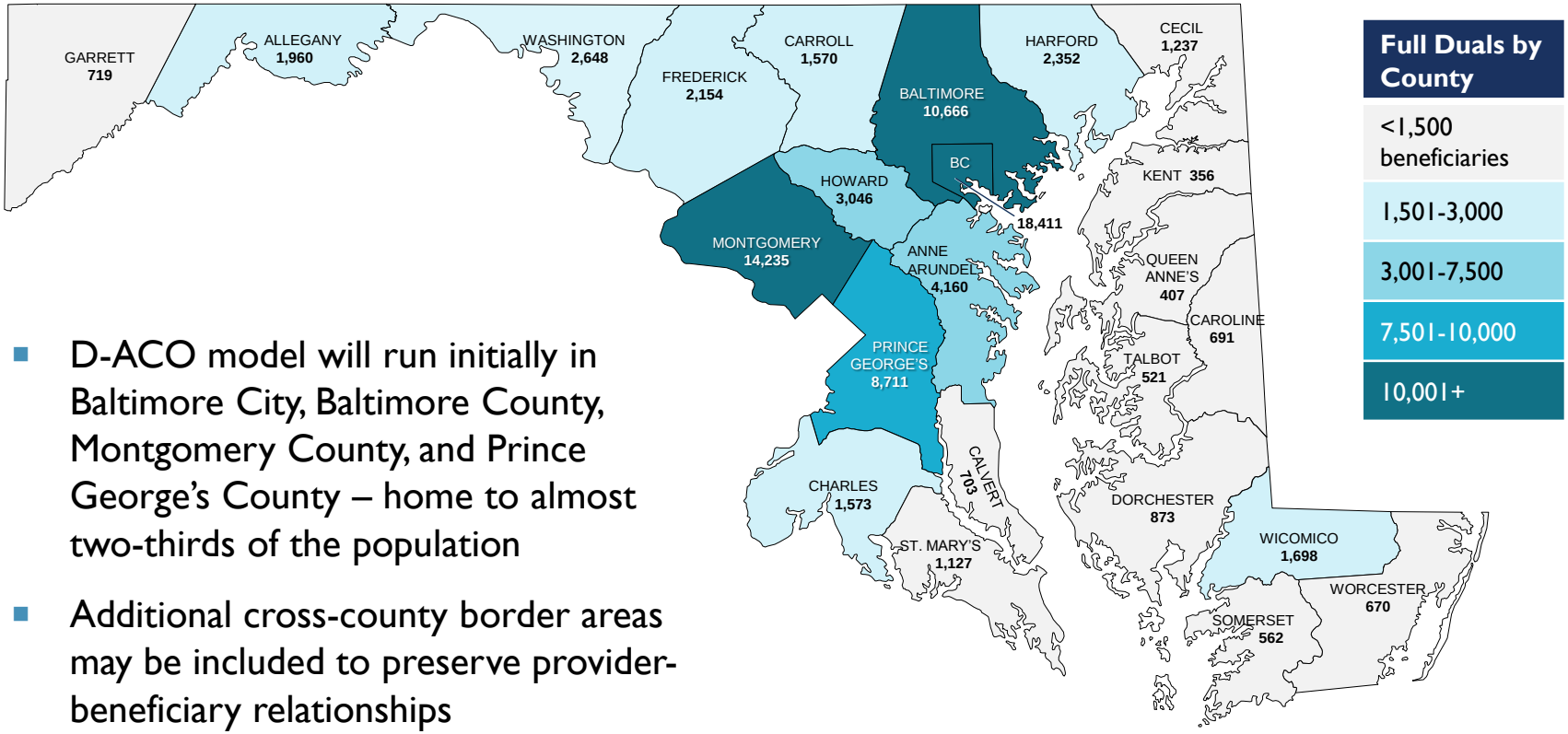
Primary Drivers

Health Home	Care Coordination	Ease of Use	Accountability
Continuous beneficiary care relationship with a principal provider	Seamless care handoffs between providers, across settings	Unified processes and reliance upon existing community resources	Incentives for quality and cost effectiveness across Medicaid & Medicare

Secondary Drivers

Health Home	Care Coordination	Ease of Use	Accountability
• Beneficiary chooses and remains formally linked to a Person-Centered Health Home (PCHH) suited to personal circumstances • PCHH is responsible for assessing needs, care planning and leading coordination of all care beneficiary needs • PCHH supported by ACO care management	• Beneficiary's medical, behavioral, LTSS and social service elements all considered in plan • Health data exchange enables real-time awareness and readiness as beneficiaries transit across settings of care • All setting-specific care coordinators sync up with PCHH to eliminate duplication or conflict	• Beneficiary's medical, behavioral, LTSS and social service elements all considered in plan • Health data exchange enables real-time awareness and readiness as beneficiaries transit across settings of care • All setting-specific care coordinators sync up with PCHH to eliminate duplication or conflict	• Care coordination is recognized as a function needing to be paid for • Providers rewarded for achieving quality and cost savings goals; moderate downside risk in ACOs • Medicaid and Medicare dollars combined to gain accountability for whole-person spending • Align with all-payer model

D-ACO WILL RUN IN MOST POPULOUS AREAS



- D-ACO model will run initially in Baltimore City, Baltimore County, Montgomery County, and Prince George's County – home to almost two-thirds of the population
- Additional cross-county border areas may be included to preserve provider-beneficiary relationships
- Potential expansion to wider area once concept proven viable

BENEFICIARY DESIGNATION TO D-ACO

With authority granted by CMS's Center for Medicaid and CHIP Services, Maryland will mandate D-ACO designation as condition of receipt of *Medicaid* benefits for non-I/DD full dual eligibles residing in the D-ACO area

- No authority is being sought to change any rules pertaining to beneficiaries' freedom of provider choice in *Medicare*
- No beneficiary lock-in to a network

  Unlike MCO* enrollment, D-ACO designation preserves a beneficiary's freedom to choose and use any Medicaid/Medicare participating provider, whether in or out of the designated D-ACO

* MCO = managed care organization, a prepaid/capitated health plan, such as in MD Medicaid HealthChoice

D-ACO DESIGNATION PROCESS BASICS

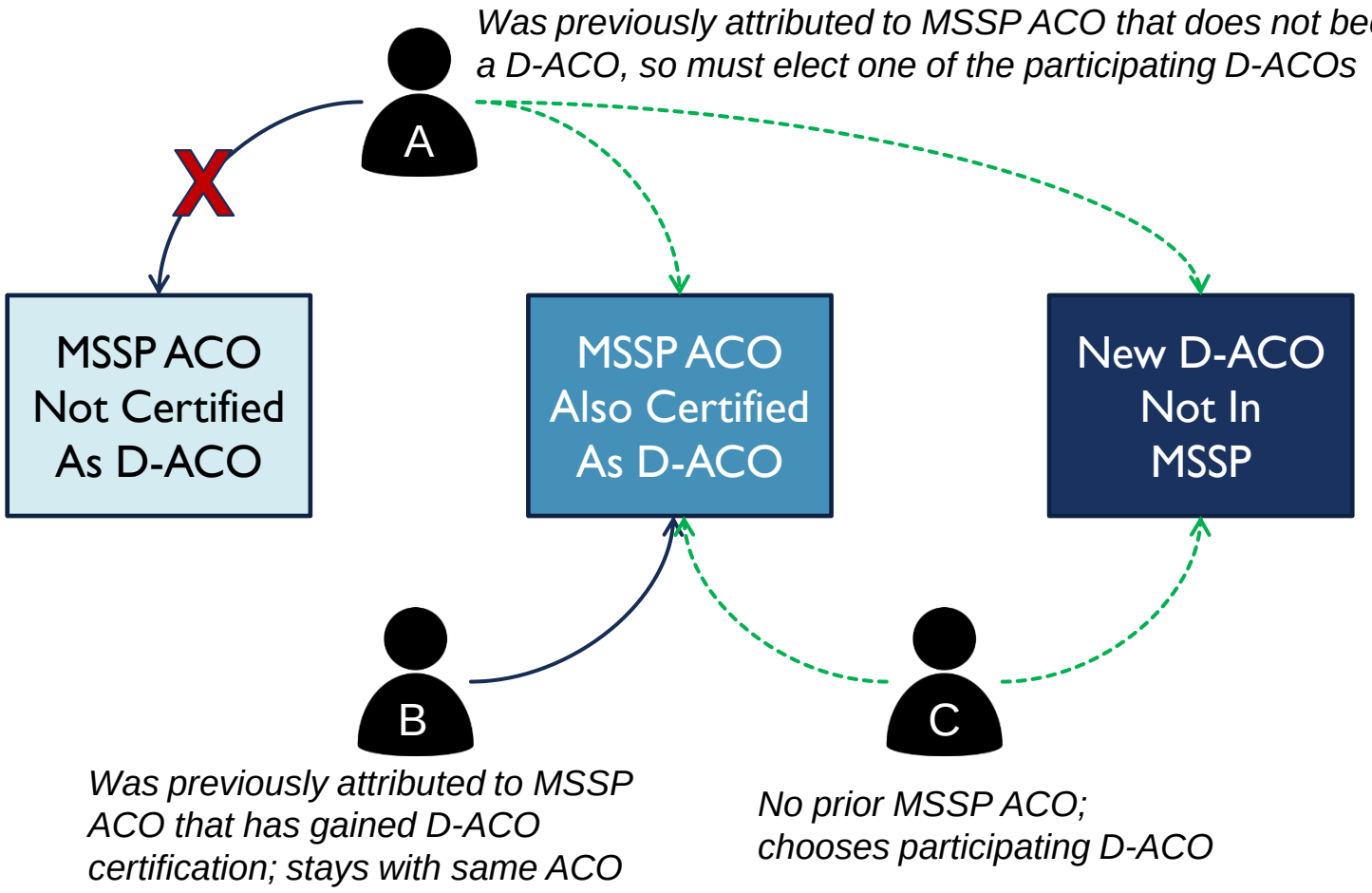
- Beneficiary will be informed of requirement to choose a D-ACO
  - Collaborative effort of DHMH and local departments of social services
  - No direct promotion by D-ACOs or providers allowed, other than sharing approved information
- Determine if beneficiary already attributed to MSSP ACO
- Beneficiary counseled on benefits of D-ACO and options available
  - Key benefit: seamless ongoing care coordination across all care domains
  - Continuing freedom of choice of providers emphasized
- Beneficiary guided to choose from available PCHH providers in D-ACOs
  - Choosing a PCHH that's exclusive to one D-ACO makes D-ACO choice plain
  - If PCHH is in more than one D-ACO, other D-ACO features will be highlighted
- Beneficiary not affirmatively selecting PCHH/D-ACO will be assigned
  - Specified time period and outreach attempts required before assignment

D-ACO ASSIGNMENT IF NO CHOICE MADE

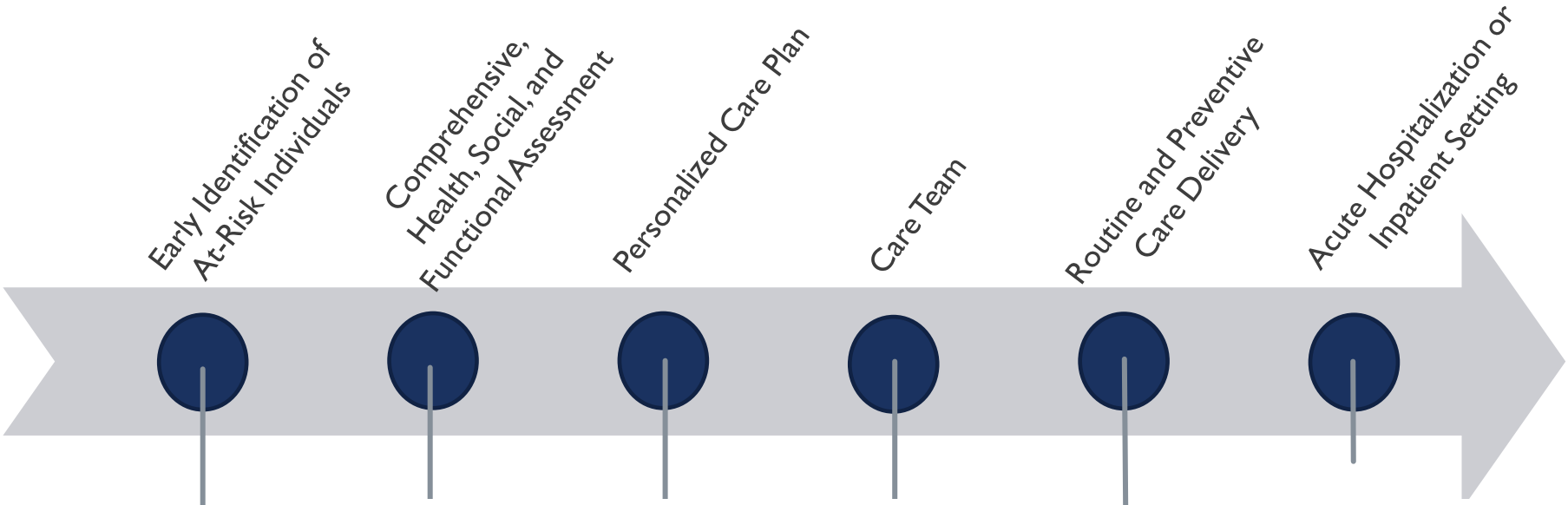
DHMH or delegate/contractor will apply decision algorithm to make best match

- Whether attributed to an MSSP-ACO that is also a D-ACO
- Recent care usage history - Medicare/Medicaid claims and CRISP utilization data - studied to assess active or recent connections to PCHH or other D-ACO providers
- Additional factors:
  - Place of residence – both geo-location and whether in custodial care
  - Health and functional conditions

PRE-EXISTING MSSP-ACO ATTRIBUTION?



CARE CONTINUUM FOR PERSON-CENTERED CARE



Data interactions (e.g., CRISP and others) notify entities and key providers (medical and social). Analysis of claims history to identify service utilization trends.

Face-to-face interaction with Clinical Outreach/Case Management personnel to develop an individualized plan. Care Team is formed based on a combination of assessment and analytics.

Beneficiary and PCHH are linked and engaged, taking steps to achieve goals in care plan

Access to member information & real-time notification to PCHH for follow-up transitional care services

D-ACO RESPONSIBILITIES

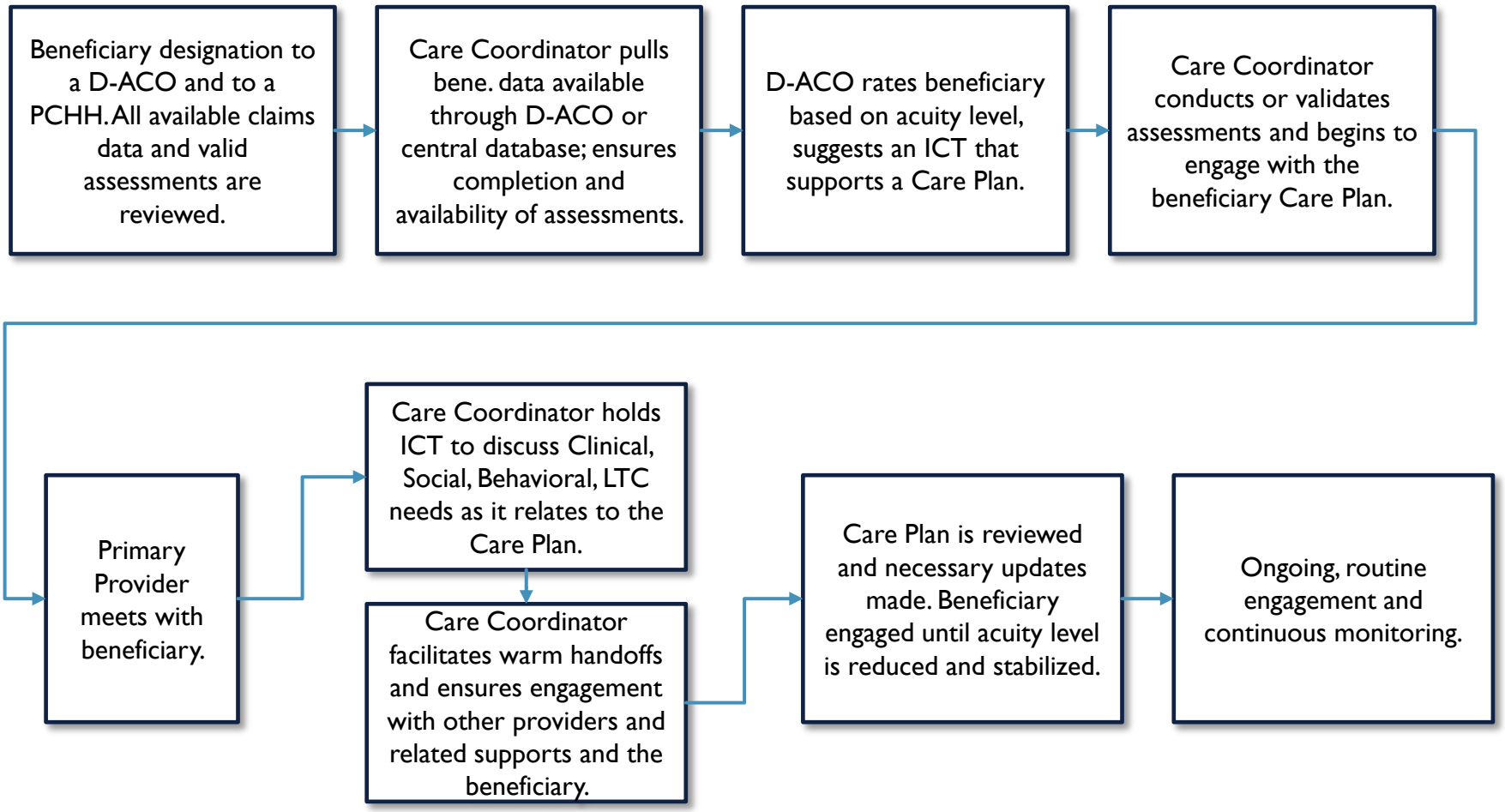
- Follow and manage beneficiaries across the care continuum
- Ensure each beneficiary is engaged with their PCHH
- Redesign care delivery and integrate primary care, behavioral health, long term care, and other specialty care
  - Offer network cross-training to ensure PCHHs have an understanding of a duals' continuum of care and the importance of integrating care, across settings
  - Encourage and provide structure to facilitate an Interdisciplinary Care Team approach
  - Offer HIT infrastructure to drive toward a centralized member record
  - Facilitate the movement toward a unified assessment and individualized, holistic care plans
  - Support a community-driven care model via agreements/contracts with community partners
- Continually analyze and report on beneficiary experience and PCHH performance

COMMUNITY ENGAGEMENT

Social factors (family/personal connections, transportation, housing, nutrition) have significant impact on health status and effectiveness of health care

- D-ACO model develops a framework that:
  - Collects information from social assessments
  - Equips D-ACO providers with information and motivation to care for each person holistically
- D-ACO model defines community engagement:
  - On macro level – how community resources at-large are engaged in the model
  - On the micro level – how D-ACO and PCHH foster relationships with community resources to support members

BENEFICIARY ENGAGEMENT WORKFLOW



COMPREHENSIVE CARE MANAGEMENT

PCHH

- Conducts screening, and assessments
- Convenes the ICT
- Serves as "quarterback" for care coordination
- Develops and maintains the Care Plan

D-ACO

- Supports the PCHH in a Care Management role
- Responsible for defining the individualized ICT
- Supports the Care Coordinator with data, to facilitate targeted interventions

CARE COORDINATION AND HEALTH PROMOTION

PCHH

- Coordinates access to services (social, behavioral, LTSS)
- Facilitate scheduling of appointments
- Provides education, motivational interviewing, and engagement with beneficiary

D-ACO

- Staffs and/or supports the Care Coordinator
- Identifies wellness and health promotion activities that would be most useful to the beneficiary

TRANSITIONAL CARE

PCHH

- Engages with the beneficiary to re-assess needs
- Re-convenes ICT
- Updates Care Plan
- Supports beneficiary and family in transitioning between settings

D-ACO

- Alerts and notifies PCHH and Care Coordinator of ED visit, ED admission, Inpatient stays, LTC facility admission

INDIVIDUAL AND FAMILY SUPPORT

PCHH

- Engages with beneficiary and family/friends to offer individualized Care Plan
- Connects with family supports and community resources to coordinate care

D-ACO

- Produces educational materials for family/friends for PCHHs to distribute
- Supports communication on program requirements and policies

REFERRAL TO COMMUNITY AND SOCIAL SUPPORTS

PCHH

- Care Coordinator identifies gaps in social needs and connect beneficiary to appropriate resources

D-ACO

- Care Manager identifies gaps in social needs and works with Care Coordinator
- Establishing relationships with community resources
- Facilitates connection between ben. and community resources

USE OF HEALTH INFORMATION TECHNOLOGY

PCHH

- At minimum, use data reports to prioritize beneficiary
- Ensures completeness of records
- Engages with beneficiary to obtain permission to share data

D-ACO

- Responsible for data exchange
- Provides actionable information to PCHHs/Care Coordinator
- Ensures HIPAA/PHI and user-level access
- Supports PCHHs and network by improving HIT infrastructure

QUALITY MEASUREMENT

- Goals for quality measurement system
  - Protect beneficiaries
  - Ensure cost savings are associated with improved quality
  - Create alignment of measurement across programs
  - Case mix adjustment where applicable
- Quality measure selection strategy
  - Ensure coverage of key domains of care for dual eligible beneficiaries
  - Utilize measures that assess quality of life
  - Rely upon validated measures from credible stewards
  - Align measures and reporting requirements with other programs and minimize number to reduce reporting burden
  - Focus process measures on care coordination

QUALITY OF CARE FOR DUALS

- National Quality Forum – Repository for systematically developed and evolving Quality Measures – uses expert panels
- "Advancing Person-Centered Care for Dual Eligible Beneficiaries through Performance Measurement" – 35 measures and also recommended starter set of core measures" August 2015
  - Cross Cutting Measures and generally not disease-specific
  - Minimize Data Collection Burden and used in other federal programs
  - "Measure Status Report" tracks NQF approved measure and identifies Measure Steward
- The Quality Horizon – the future
  - electronic Clinical Quality Measures – eCQMs
  - ICD-10 – Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65, e.g. Z59.0 Homelessness)
- Community Integration/LTSS focused measures are still under development
  - NQF - "Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement." September 2016 http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

D-ACO CORE QUALITY MEASURES (1 OF 2)

Measures	Data Source	Focus	NQF #/Measure Steward
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims/ E H R	B, M	4/NCQA
CAHPS Health Plan v 4.0 - Adult questionnaire	Beneficiary Reports	M	6/AHRQ
Controlling High Blood Pressure	Under Reconsideration NQF	O, C, M	18/NCQA
Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention	Claims/E H R /Paper or Registry	C, S, M	28/AMA Consortium
Medication Reconciliation - Post Discharge	Claims/E H R /Paper or Registry	C, S, M	97/NCQA
Falls: Screening, risk-Assessment, and Plan of Care to Prevent Future Falls	Claims/E H R /Paper	M	101/NCQA, AMA Consortium
3-Item Care Transition Measure at Hospital Discharge (Needs, responsibility and medications)	Beneficiary Reported Data	S	228/University of Colorado
Advanced Care Plan	Claims/E H R	S, M	326/NCQA, AMA Consortium
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Claims/Paper/Other	B, M	418/CMS, Mathematica, Quality Institute of PA

Legend for Focus Areas:

B = Behavioral; O = Outcome; C = Consensus Core Set, S = Shared Savings Program, $ = Efficiency Coordination Opportunity

M = MACRA - For a list of MACRA Quality measures see Federal Register, Volume 81, No. 89; May 9, 2016; pages 28399 - 28586.

D-ACO CORE QUALITY MEASURES (2 OF 2)

Measures	Data Source	Focus	NQF #/Measure Steward
Documentation of Current Medications in Medical Record	Claims/Other/Registry	S, M	419/CMS, Mathematica, Quality Institute of PA
Adult Weight Screening and Follow-up	Claims/Other/Paper/Registry	C, M	421/CMS, Mathematica, Quality Institute of PA
Follow-Up After Hospitalization for Mental Illness	Claims/E H R	B, M	576/NCQA
Timely Transmission of Transition record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Claims/Other/Paper	$	648/AMA Consortium
Plan All-Cause Readmissions	Claims	$	1768/NCQA
Antipsychotic use in persons with dementia (New Measure)	Claims	B	2111/Pharmacy Quality Alliance
Sepsis - Appropriate treatment of MSSA (Methicillin-sensitive Staphylococcus aureus) Bacteremia	Claims/E H R	M	CMS 407/Infectious Disease Society of America

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ADMINISTRATIVE CARE MANAGEMENT FEE

- Additional care management fee to supplement revenue from claims and shared savings
- Intended to ensure availability of intensive care management and coordination services without regard to timing or amount of shared savings
- Two Payments
  - Initial Care Planning Payment
    - One-time payment for completion of the care plan to compensate for higher outreach, engagement, assessment, and care planning costs (equal to 2 or 3 months of ongoing PBPM payment)
  - On-going PBPM – expected to equal no more than 2% of TCOC
    - Tiered based on beneficiary risk stratification
    - Payment begins 1st month following initial care planning payment and continue as long as beneficiary is designated to D-ACO and care plan continues to be managed and updated
    - No claim or encounter required following initial care plan

D-ACO RISK-SHARING

- Higher D-ACO sharing in outcomes as results deviate more from target
- Better financial result for D-ACO as quality rises
- No risk of loss for D-ACOs in initial two-year shake-out period

		Losses (Yr. 3 & After)			Savings		
	Actual Spend vs. Target:	> 5%	2 - 5%	0 - 2%	0 - 2%	2 - 5%	> 5%
D-ACO Quality Rating	Highest	20%	10%	0%	40%	50%	60%
	High	30%	20%	10%	30%	40%	50%
	Acceptable	40%	30%	20%	20%	30%	40%
	Less Than Acceptable	50%	40%	30%	0%	0%	0%

In years 1-2, a D-ACO has no downside risk; its share of any loss = 0%

Quality rating must be at least Acceptable for D-ACO to earn any savings award

RISK MITIGATION

- Specific stop-loss – to ensure that the very highest cost cases do not swamp otherwise effective care/cost management
  - In reconciling the risk/reward opportunity at the end of each performance year, the most costly 1% of D-ACO attributed beneficiaries will be excluded
  - To account for the above when computing the baseline TCOC target, claims expenses will be truncated at the 99th percentile of population spending – that is, the 1% most costly people will be excluded
- Aggregate stop-loss – to limit D-ACO's overall exposure on the downside
  - Any D-ACO loss share owed to the government will be capped at 5% of the TCOC target

D-ACO INCOME ILLUSTRATIONS (1 OF 3)

Hypothetical example 1 – Actual TCOC exceeds target

Suppose:

- A D-ACO gets 4,000 aligned beneficiaries
- The average care coordination payment is $60 PBPM, or $720 PBPY
- The TCOC target is $3,500 per beneficiary per month, or $42,000 PBPY
- The D-ACO loses 2.5% against the TCOC target and quality rating is Acceptable

Then:

- D-ACO receives $2,880,000 to support care coordination efforts in real time
- D-ACO's aggregate TCOC target = $168,000,000; care costs = $172,200,000

If Year 1 or Year 2:

- D-ACO is not required to pay any share of the $4,200,000 excess cost

If Year 3 or after:

- D-ACO owes 30% share of loss, or $1,260,000

D-ACO INCOME ILLUSTRATIONS (2 OF 3)

Hypothetical example 2 – Modest gain

Suppose:

- A D-ACO gets 4,000 aligned beneficiaries
- The average care coordination payment is $60 PBPM, or $720 PBPY
- The TCOC target is $3,500 per beneficiary per month, or $42,000 PBPY
- The D-ACO saves 1.8% against the TCOC target and quality rating is Acceptable

Then:

- D-ACO receives $2,880,000 to support care coordination efforts in real time
- D-ACO's aggregate TCOC target = $168,000,000; care costs = $164,976,000
- At year's end the D-ACO receives a 20% share of $3,024,000, or $604,800

D-ACO INCOME ILLUSTRATIONS (3 OF 3)

Hypothetical example 3 – Good gain

Suppose:

- A D-ACO gets 4,000 aligned beneficiaries
- The average care coordination payment is $65 PBPM, or $780 PBPY
- The TCOC target is $3,800 per beneficiary per month, or $45,600 PBPY
- The D-ACO saves 3.0% against the TCOC target and quality rating is High

Then:

- D-ACO receives $3,120,000 to support care coordination efforts in real time
- D-ACO's aggregate TCOC target = $182,400,000; care costs = $176,928,000
- At year's end the D-ACO receives a 40% share of $5,472,000, or $2,188,800

ON TRACK TO DECEMBER 31

	October	November	December
Concept Paper		Update Concept Paper and Draft Incorporate Design Elements	**Deliver Concept Paper: December 31**

Workgroup Meetings	• Workgroup Meetings
	• Subgroup Meetings
	  • Care Redesign
	  • Risk Adjustment
	  • Data
		Workgroup Meeting: October 18	Workgroup Meeting: November 15

CMS Interaction	Share concepts and model development work with CMS through October and November. Receive and incorporate feedback in the same time frame.		